



STATE MEDICAID DUR BOARD MEETING
THURSDAY, April 9, 2009
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 125

MINUTES

Board Members Present:

Mark Balk, PharmD.
Neal Catalano, R.Ph.
Derek Christensen, R.Ph.
Bradley Pace, PA-C
Colin VanOrman, M.D.

Peter Knudson, D.D.S.
Wilhelm Lehmann, M.D.
Tony Dalpiaz, PharmD.
Dominic DeRose, R.Ph.
Joseph Yau, M.D.

Board Members Excused:

Bradford Hare, M.D.

Joseph Miner, M.D.

Dept. of Health/Div. of Health Care Financing Staff Present:

Lisa Hulbert, R.Ph.
Tim Morley, R.Ph.
Duane Parke, R.Ph.

Merelynn Berrett, RN
Carol Runia
Deborah Harrington, R.N.

Other Individuals Present:

Steve Hill, Daiichi Sankyo
Felicia Fuller, Pfizer
Shawn Prince, Elan
Barbara Boner, Novartis
Lori Howarth, Bayer
Sue Heineman, Pfizer
Mandy Hosford, AstraZeneca

Roy Lindfield, Schering
Mary Ann Paul, DRRC
Larry Martinez, J&J
Ann Gustafson, GSK
Tony Molchan, Abbott
Tamara Lewis, IHC
Christina Beckwith, DRRC

Judy Christensen, Pfizer
Bryan Larson, DRRC
Eliot Brinton, U of U
Alan Bailey, Pfizer
Gary Bailey, Forrest
Joe Busby, Lilly

Meeting conducted by: Colin VanOrman, M.D., DUR Board Chairman

1. Approval of Minutes: Derek Christensen moved to approve the minutes. Tony Dalpiaz seconded the motion. The minutes were approved with unanimous votes from Derek Christensen, Mark Balk, Tony Dalpiaz, Neal Catalano, and Dominic DeRose, and Colin VanOrman.
2. P&T Committee Update: Duane Parke addressed the Board. The Legislature imposed a Prior Authorization requirement for non-preferred products that will go into effect on May 15. The PA criteria will be presented to the P&T Committee in draft form next week.

3. Housekeeping: Members of the public were asked to sign in on the attendance roster and provide an email address if they wish to receive email updates from the DUR Board.

Dr. VanOrman reminded individuals addressing the DUR Board to please disclose conflicts of interest, perceived or otherwise, when addressing the Board. Comment should be kept to under 5 minutes if possible.

4. Smoking Cessation – Class Review: Dr. Christina Beckwith addressed the Board. There were several questions raised in response to the smoking cessation review presented in February. The Drug Information Service prepared a report in response to those questions.

Lisa Hulbert prepared a comparison of coverage policies from various Medicaid agencies throughout the United States. This was summarized in a table and presented to the Board. Utilization information from Utah Medicaid was also presented to the Board.

Dr. Measom addressed the Board. Nicotine addiction is a chronic relapsing medical condition that is the number one cause of mortality in the U.S. Clinically, when he sees patients who want to quit, they have often tried patches and nicotine replacement. The reason that he uses Chantix is because it works. He is also a proponent of behavioral therapy. He would hate to see a patient develop cancer 10-15 years down the road due to a decision made by the Board today. He also understands that the way the law is written, psychotropic medications are not to be restricted in any way. He would suggest that Chantix is a psychotropic medication because it works centrally in the brain, works on the reward center in the brain, and has a huge benefit. This is an important product, and he asked the Board members to consider what product they would want for a family member who smokes.

Duane Parke asked where the patient's responsibility to quit comes in. Is Medicaid being co-dependent by providing this medication indefinitely? Dr. Measom stated that there are two things going on in the brain. The cortex uses reason, and that is where the where behavioral therapy comes in. The deeper structure of the brain is responsible for craving and urges, and this is where the psychotropic medication works. He is amazed that people are told to "Just Say No" to deal with a biochemical dysfunction of the brain.

Dr. VanOrman asked Dr. Measom if there are any conflicts that he wanted to disclose. Dr. Measom is a promotional speaker for many pharmaceutical companies. He speaks for Pfizer on behalf of varenicline approximately 3 times per year.

Lisa wanted to clarify that Medicaid takes exception to the statement "no restrictions whatsoever on psychotropic medications". There are limits on toxic levels, DUR alerts, and age limits. Dr. Measom stated that he sees this as discrimination.

Dr. Sue Heinemen of Pfizer addressed the Board regarding the superiority of varenicline over other smoking cessation products and the impact of smoking cessation on Medicaid costs.

The Board asked Dr. Heineman if she had any comments regarding some of the emerging side-effect data of varenicline. She stated that it is difficult to put a true prevalence rate on some of the side-effects that are being reported in the lay press. Pfizer is in constant contact with the FDA regarding this. Some of the behaviors seen may be due to nicotine withdrawal versus varenicline.

Dr. Measom stated that when he sees clients in post-acute withdrawal, this is a common occurrence regardless of the substance that is being withdrawn.

Dr. Yau stated that there is a need for clinicians to be able to choose from a variety of smoking cessation products based on contraindications in certain individuals with certain products.

Dr. Tamara Lewis of Intermountain Healthcare addressed the Board. She said that she does not have any financial ties with drug companies, but does represent several hundred Primary Care Physicians from IHC. IHC has done cost modeling for various modalities of smoking cessation. IHC actually makes money when individuals quit smoking. One of the key barriers to smoking cessation is lack of coverage. Clients on nicotine replacement therapy are required to participate in a behavioral component to increase the quit rate with that treatment modality. In IHC, each product only be used for 26 weeks per year, but there is no lifetime limit. It is easier for physicians to have similar benefit structure among insurers.

Dr. Yau asked what the risk is of side effects cost-wise in IHC's cost studies. Dr. Lewis stated that the cost modeling did not take into account the diagnoses of per member per month costs from an actuarial standpoint. Also, prescribers usually discontinue therapy if patients have too many adverse events.

The Board asked if it was possible for Medicaid to look at adverse outcomes with the various tobacco quitting treatments. Lisa and Duane did not feel that this was feasible based on the claims level detail that Medicaid receives.

The Board felt that the IHC model appeared to be working well and restricting the use of varenicline to 26 weeks per year and requiring counseling for nicotine replacement could be helpful.

Mark Balk moved that Medicaid maintain access to all products, limit varenicline to 26 weeks per year, and ask pharmacists to provide information on the Tobacco Quit Line to patients who receive smoking cessation products. Utilization data should then be reviewed within the year.

Duane suggested that patients receiving nicotine replacement could receive a mailer from Medicaid advising them to enroll in the Tobacco Quit Line.

Dr. Measom stated that any barriers imposed by a third-party payor make it more difficult to treat an addiction. If varenicline is only approved for 26 weeks per year, a patient may start and stop therapy repeatedly throughout the year.

Dr. Yau stated that he feels that behavioral counseling will increase the success rate, but it may make it easier for the behavioral component to be a recommendation rather

than a mandate. He also asked if the motion would include time limits on other treatment modalities.

Lisa asked Dr. Lewis how IHC handles counseling as a part of the nicotine replacement. IHC sends nicotine replacement upon enrollment in the counseling program. Providers are not required to document enrollment.

The Board asked if patients could be sent letters upon filling a prescription for nicotine replacement. Dr. Measom felt that this was helpful.

Jennifer stated that only about 300 distinct recipients received nicotine replacement therapy in calendar year 2008. It would not be too onerous to pull recipient data monthly or quarterly and send the patients a letter.

Mark Balk re-stated his motion to do something in terms of education for smoking cessation products, and limit varenicline to 26 weeks per year with no lifetime limit.

Neal Catalano seconded the motion with the provision that the 26 weeks per year need not be consecutive for varenicline treatment.

The motion passed with unanimous votes by Derek Christensen, Mark Balk, Tony Dalpiaz, Neal Catalano, Dominic DeRose, Dr. Yau, Dr. Lehmann, Dr. Hare, Bradley Pace, and Dr. Knudson.

5. Low Molecular Weight Heparins in Cancer: Marianne Paul from the University of Utah Drug Information Service addressed the Board and presented evidence prepared by the University.

Lisa provided the Board with Medicaid's current criteria for LMWH.

Mark Balk moved to add treatment or secondary prevention of VTE in patients with cancer for 12 month periods. Renewal criteria for the PA would be the same as initial. Utilization data should be reviewed in 9-12 months.

Derek Christensen seconded the motion. The motion passed with unanimous votes by Derek Christensen, Mark Balk, Tony Dalpiaz, Neal Catalano, Dominic DeRose, Dr. Yau, Dr. Lehmann, Dr. Hare, Bradley Pace, and Dr. Knudson.

Next meeting set for May 14, 2009
Meeting adjourned.

The DUR Board Prior Approval Subcommittee considered 4 petitions this month.

Minutes prepared by Jennifer Zeleny